STATE OF WISCONSIN

EMPLOYER VERIFICATION OF HEALTH INSURANCE

TO BE COMPLETED BY THE EMPLOYER

EMPLOYEE, Please return this **original (not a copy)** form to
State of Wisconsin, P.O. Box 6530, Madison, WI 53716-0530 by : 05/16/2004

EMPLOYER INFORMATION
EMPLOYMENT INC.
123 FIRST STREET
MADISON WI 53434-2837
FEIN: 9876543210
FAX: (608)123-4567

EMPLOYEE INFORMATION
JOHN SMITH
456 SECOND STREET
MADISON WI 45232-8102

SSN: 123123123

We require major medical health insurance information concerning the employee named above. This form will be scanned. Please complete this form using only **blue or black** ink and return to the employee. If you have questions, please call JANE JONES at (608)987-6543. Thank you for your cooperation.

HEALTH INSURANCE INFORMATION	
Is the employee listed above currently employed by you?	◯Yes ◯No
Is this employee now or has s/he, within the last 12 months, been covered under your employer-provided major medical health plan?	◯Yes ◯No
If "Yes", what date did coverage begin?	__/__/__ MM/DD/YY
If coverage has ended, what date did it end?	__/__/__ MM/DD/YY
Which family members are/were covered under the plan? (Please indicate all that apply)	◯Employee ◯Spouse ◯Children ◯Step-children ◯Other
Could this employee enroll in and receive family coverage under an employer-sponsored group health plan in the current month?	◯Yes ◯No
If "Yes", would the employer pay at least 80% of the premium?	◯Yes ◯No
Which family members could be covered under this health plan? (Please indicate all that apply)	◯Employee ◯Spouse ◯Children ◯Step-children ◯Other
Will the employee be able to enroll in and receive family coverage under an employer-sponsored group health plan in the next 12 months?	◯Yes ◯No
If "Yes", what is the date employee will have access?	__/__/__ MM/DD/YY
Does the employer contribute at least 80% of the premium?	◯Yes ◯No
Does this employee have access to the Wisconsin state employee health insurance plan or any other state's employee health insurance plan through his or her employment?	◯Yes ◯No

Signature of the Employer / Designee: _____	Date: __/__/__
Title: _____	Tel: ___-___-____
Email: _____	FAX: ___-___-____

For Office use only

Case	4102036741	PIN	7501559279	Emp-Seq	005	Conf	N
Trg-Dt	041904	Due-Dt	051604	Wkr-Id	JX1234	Form	H